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ABSTRACT

The newsletter's main article focuses on hyperactivity and attention deficit disorder. The causes of hyperactivity, which affects 3-5 percent of all children, are elusive but may include neurological immaturity, inherent genetic problems, or fetal exposure to harmful substances. Patterns of behavior that typify a hyperactive child include a short attention span, extreme impulsivity, disorganization, constant movement, difficulties in coordination, attention-demanding behaviors, domineering personality, lack of judgment, and mood swings. Help can be provided in several ways. Medications, usually stimulants but occasionally major tranquilizers, can be prescribed. Some claim that dietary changes to eliminate sugar, food additives, or allergens also help. Psychological help can enhance self-esteem and peer relationships. Additional suggestions include teaching self-control, accentuating the positive, encouraging physical activities, reducing outside stimulation, adhering to a consistent schedule, avoiding overload, and promoting self-esteem. A question-and-answer section provides specific advice on toilet training and on pinpointing problems in a developmentally disabled child so that an appropriate program can be developed for him. Another section focuses on children with Attention Deficit Disorder and hyperactivity, detailing their special problems, their need for a well-structured predictable school environment, and the use of psychotherapy and/or medication to assist them. (VW)

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HYPERACTIVE CHILD

Special Parent*Special Child
Vol. 3, No. 5
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Special Parent ★Special Child

Practical pointers for parenting handicapped children

VOL. 3, NO. 5 SEPTEMBER/OCTOBER 1987

THE HYPER-ACTIVE CHILD

". . . My child is in constant motion; he was a fussy baby and now that he's older he still can't seem to settle down. He flits around from one thing to another but doesn't appear to be interested in anything for very long. He's not a **bad** child—it's just that he's so disruptive and distractible he can't follow directions or obey any rules. He's so bossy that he's always in trouble in school with classmates, his teachers and the rest of the neighborhood. We love him, but wherever he goes there's chaos. I've always figured he was a hyperactive child but the doctors say he has **attention deficit disorder—ADD**. Pinning a label on my son doesn't help him behave any better or make life easier either. Somewhere inside this bleak picture there is a little boy we love, but how are we going to help?"

In response to many reader inquiries similar to the one above, this issue will examine the problem of hyperactivity and the best ways of dealing with the hyperactive child at home and at school.

What causes hyperactivity?

No one is quite sure of the cause but psychiatrists and other doctors, puzzled by otherwise healthy children whose misbehaviors and persistent distractibility couldn't be attributed to any problem in the home, theorized that somehow it is inborn in the child. More boys than girls are affected, and it is estimated that from three to five per cent of all children are hyperactive, to some degree or other.

Although there is no firm evidence, some clinicians feel that neurological immaturity or an inherent genetic problem might be the cause. Even fetal exposure to harmful substances such as environmental pollutants or food additives has been considered as the possible culprit.

However elusive the cause, hyperactive children who are suspected of having ADD share similar patterns of behavior.

Patterns of behavior

The ADD, hyperactive child generally has a **short attention span** and is easily distractible. The child with this problem doesn't seem to be able to complete any task unless given one-to-one direction. Often parents find themselves in endless confrontations, nagging constantly, "Finish your homework, finish the dishes, you didn't finish making your bed." The hyperactive child is so distractible he literally seems to suspend his activity in mid-air, going on to something completely different, oblivious to the tasks he's left undone or half completed.

He is extremely impulsive. "He wants what he wants when he wants it." Taking other people's possessions without heeding the rightfulness or wrongness of his actions, running into traffic to retrieve a ball with no awareness of the inherent dangers, inability to profit and learn from previous mistakes are all examples of behaviors that lead to troublesome family relations. Acting without forethought is coupled with punches, fist fights and verbal confrontations with siblings or playmates who refuse to play the game his way. He has difficulty conforming to rules or waiting his turn, demanding instant gratification of his needs.

The hyperactive child is disorganized. He often is unable to plan effectively or carry through to completion even simple tasks on his own. He often appears disheveled, shirt tails flapping, laces untied, and, moreover, is often unaware or unconcerned that this is the case.

The hyperactive child appears to be on the move. He seems driven by some constant inner need to touch, tap, fidget, squirm, push, knock over or kick. It's as if his body is in high gear at all times, with a marked inability to shift into low.

As an infant he was a poor sleeper, seldom napped, awoke at the slightest sound, slept fitfully and never through the night. These sleep disturbances often continue unabated as he grows older.

As a toddler he was not only into everything but there was seemingly little purpose to his ceaseless activity. Toys were not played with; they were broken or thrown. Books were ripped and attempts to engage him in shared play or story telling met with fidgets, squirms and outright running away. Whereas a normal toddler can sit quietly for at least short periods of time to color or put together a puzzle, the hyperactive toddler is unable to sustain any play activity for more than a few seconds. Crayons are broken and puzzle pieces discarded in his wake as he flits to yet another activity. One harassed mother described her child as "a disaster waiting to happen."

Although many active toddlers appear to behave in a similar fashion, the major difference between the normal toddler and the hyperactive youngster is that the normal child is able to lower his activity level, listen for direction and, most tellingly, is able to **stop** on his own.

ABOUT SPECIAL PARENT/SPECIAL CHILD:

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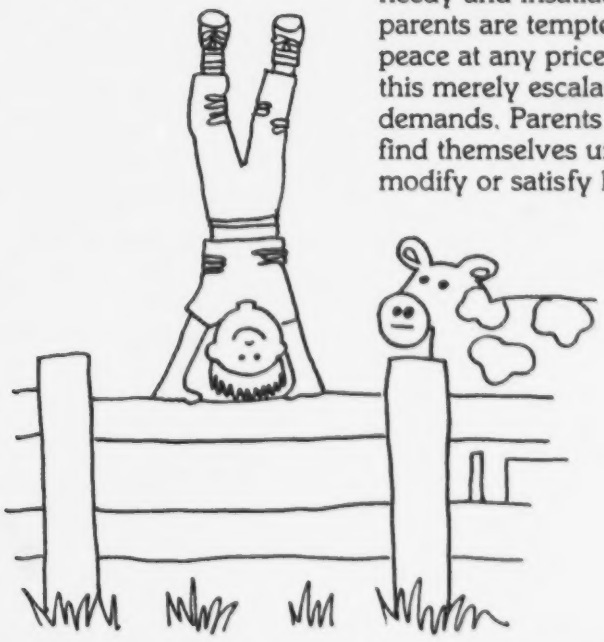
During childhood the hyperactive youngster continues to fidget, is unable to sit through a meal, for example, or even watch a favorite TV program without roaming around the house. Teachers at school report he is unable to sit at his desk and that he speaks out of turn and frequently annoys others.

Difficulties in coordination are often noted. Many hyperactive children appear somewhat gawky and less coordinated than their peers. Throwing or catching a ball and other activities requiring hand-eye coordination are problems for them. However, many hyperactive youngsters excel in sports such as swimming where this is not a factor. Typically, the hyperactive child has serious difficulties in activities involving finger dexterity such as handwriting, coloring, cutting with scissors and other school-related tasks.

Attention-demanding behaviors cause grave concern both at home and at school, for the hyperactive child demands center stage at all times. Because he appears so needy and insatiable, guilt-ridden parents are tempted to pay for peace at any price. Unfortunately, this merely escalates the child's demands. Parents and siblings find themselves unable to control, modify or satisfy him. The foot-stamping, whining, into-everything toddler becomes the driven, annoying, demanding, show-off child or adolescent.



The hyperactive child is, above all, domineering. He insists on being first in line at school and served first at the dinner table at home. He frequently sees himself as the "boss," barking orders indiscriminately, resisting all rules and regulations not his own. Siblings and friends find him a difficult companion. Games must be played his way or not at all. He is often aggressive and becomes known as the playground bully. He upsets others to the point where he is virtually friendless, unless he finds younger children who are more likely to tolerate his bossiness.

He often lacks judgment which manifests itself as total fearlessness, swinging from trees, playing on or near railroad tracks, annoying animals to the point of endangerment.

The hyperactive child is often beset with mood swings. He appears elated one minute, despondent the next, with no rhyme or reason or direct relationship to anything in the environment that could cause such sadness or joy. Parents find themselves at wits end trying to provide him with stability or comfort. Even minor incidents in their hyperactive youngster's life can trigger major temper tantrums. The hyperactive child is over excitable and short-fused, with such low frustration tolerance that even the most mundane events often produce prolonged loss of control.

The end result of a hyperactive child's driven behavior is ultimately a child at odds with himself and the world—endlessly wronged, different, friendless, a saddened child with little or no self-esteem.

How can we help?

ABOUT THE AUTHORS

Linda Murphy, M.S., is the founder and for the past 15 years has been the director of a widely known, approved school for mentally handicapped children serving children ages 5-21 in Westchester County, NY, and surrounding areas. A lecturer, teacher and administrator, she is a foster parent and the parent of a handicapped child, too.

Suzanne Della Corte, M.S., for 15 years co-director of the school, is responsible for curricula, staff development and supervision. She is author of numerous research projects in the field and has edited psychology textbooks for a leading New York publisher.

Medical treatment. The first step is to seek medical advice if your child displays any or all of the above troublesome patterns of behavior. Dismissing your youngster's problems as just garden-variety hyperactivity or ignoring the problem will not help, especially if the hyperactivity is masking other underlying causes. Only a physician skilled in diagnosing this type of disorder should make a definitive diagnosis.

Hospitals and clinics that offer a multidisciplinary team approach—including the services of a pediatrician, neurologist, psychologist, psychiatrist—are best. These specialists will examine your youngster, go over his previous medical histories, and after a thorough review will have a conference with you to disclose their findings. If they diagnose your child as hyperactive ADD, they will design a course of treatment and will monitor your youngster to make sure he is being helped.

One form of medicine or treatment plan that is helpful to one child might not work with yours. It is vital to **stay connected to your child's medical team** for frequent updates, especially as he grows older and his metabolic needs change.

Medicines are often indicated. Many hyperactive children react positively to certain specific drugs. Frequently, this is the only kind of treatment necessary to bring the child to full functional ability. Most parents are uncomfortable with the idea that their youngster requires medication, especially for any length of time. The best attitude to adopt is that, for all intents and purposes, hyperactivity **is** a physical problem and that medicine is required to control the disorder much as if the child had diabetes or seizures and needed medical treatment for relief.

Two types of medication are frequently indicated. The most commonly used are **stimulant drugs** such as Ritalin®, Cyclert®, or Dexedrine®. Although stimulants, these have the paradoxical effect of calming down hyperactive children. They increase the child's attention span, reduce jittery behaviors and help the child manage better at home and school.

Occasionally **major tranquilizers** such as Mellaril®, Haldol®, and Stelazine® are indicated, especially when the child has sleep disturbances or intense feelings of anxiety.

As with any medication, parents should follow dosage directions carefully. The child should be observed closely and the doctor should be contacted if there are any changes. Drugs have possible side-effects and parents should be aware of the effects, if any, of long-term dosage.

Diet. The possiblity that certain foods or sensitivity to food additives or other allergies can cause hyperactivity remains controversial. Special diets, it is claimed, have helped children. In specific circumstances some food substances can cause behavioral symptoms. Sugar, food dyes, and other additives have been suspected as offending substances for susceptible children. As this is very difficult to document, parents are advised to consult a pediatrician, an allergist, and a medical doctor specializing in nutrition before undertaking any

special diets or vitamin therapies for their hyperactive child. A balanced diet, low in sugar and fat but with plenty of fresh fruits, vegetables, whole grain products, lean meats, fish, and milk products should benefit the entire family.

Psychological help. Often the hyperactive child responds to psychological help. The disorder has the effect of harming the child's self-esteem and ability to form friendships to the point where psychological intervention is often indicated.

Most hyperactive children are unhappy about their runaway emotions and loss of control. They seek protection from their own impulsive drives—they need parents who can limit as well as love.

This is easier said than done, of course. Parents should seek support groups and avail themselves of professionals who can help set up a consistent program of behavior modification. The use of praise and rewards in working on those behaviors that are most troublesome requires help from trained experts.

Do's and don'ts

• **Do remember that teaching self-control is a must.** Saying to your child and others, "Johnny can't help it, he's hyperactive," will only serve to reinforce Johnny's inappropriate behaviors. Hyperactive children respond best to structure and external limits that are fair, uncomplicated, and consistent. Expecting appropriate behavior and compliance to a simply-stated rule for a minimal task or time frame is a good way to start.

• **Do accentuate the positive.** Find some simple activity that your child genuinely enjoys. Praise him often for any positive behaviors you observe. Most often, hyperactive children function best in a one-to-one situation, free from external distractions or noise.

A hyperactive child, above all, needs someone caring enough to organize, plan, supervise, and provide the structure he cannot organize on his own.

• **Do encourage your hyperactive child to engage in activities** that will burn off excess energies—for example, jogging, track, long-distance running, swimming laps and other endurance sports that don't require hand-eye coordination.

• **Do be aware that hyperactive youngsters** are frequently insensitive to pain and can sustain cuts and bruises with little discomfort. Parents should also be aware, however, that **overreaction** to minor hurts is an attention getting device.

• **Do keep outside stimulation to a minimum.** Hyperactive children cannot screen out environmental noise or movement, frequently reacting to even normal household sounds with adverse reactions. Blaring TVs, whirring household appliances, even people conversing in normal tones are distracting enough to trigger frantic behavior.

• **Do adhere to a consistent schedule.** Having dinner, bedtime and other activities at reliable times can ease some of the disorganization.

• **Don't overload your youngster with too many things at once.** Avoid giving too many directions. "Make your bed, get dressed, come and eat breakfast,

we're leaving soon," is too much for an ADD child to handle. Select one activity at a time, provide plenty of supervision and verbal praise for successful completion of just one task.

• **Do promote your hyperactive child's self-esteem.** Encourage him to participate in an activity he enjoys and make sure he receives recognition for it. Be on the lookout at all times for any opportunity to boost his ego.

• **Do provide supervised recreational experiences for your child.** Free time is often the worst time of all. A swim club, horseback riding instruction, even a short walk together are alternative ways of providing organization for him.

• **Do see him as a child capable of surmounting his difficulties.** Don't blame or deny. Be honest with him about his difficulties but let him know that you love him and that the whole family will work together to help achieve as much of his potential as possible.

THE READER ASKS . . .

QUESTIONS AND ANSWERS

We invite inquiries or hints from our readers. If you have a question, a problem or comment about any aspect of parenting special children, write to:

Special Parent/Special Child
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South Salem, NY 10590

Q. "My son, age 5½, is only partially toilet trained and continues to soil his pants. Even though he seems to know what is expected of him, he won't do it. Can you give me some suggestions?"

A. The easiest and most effective method involves the use of behavior modification. First try to establish the times of the day your son usually eliminates. If your child is not afraid of the toilet and is willing to sit on a potty chair, then place the child on the toilet during the times when there is the greatest probability he will go. If he does, reward your child with praise, a hug, and some other reinforcement, e.g. food tidbits your child likes. Becoming angry or punishing your child for soiling himself might very well be counterproductive. It may take a bit of time, but, assuming there is no physical or serious mental problem, this procedure can be very useful. You may wish to consult a professional for additional help and guidance.

Q. "We've just been told that our son, age 6, is developmentally disabled. He is unable to cut with scissors or even color. We can't tell if he is right or left-handed as he doesn't use either hand consistently. What causes this? What can we do to help him?

A. Developmental disability is a catchall term that includes a number of very different disabilities. It is important to pinpoint your son's problem as much as possible. A thorough medical and neurological evaluation would be the first step. The next would be a complete psychological and educational assessment. Based on these evaluations and with the help of your school district, you should be able to find an appropriate program for your child, one that is specifically designed to meet his needs.

Psychologist's corner: ADD & HYPER-ACTIVITY IN THE CLASSROOM

by George Popper, Ph. D.

David is an attractive, verbal, six-year-old. He comes from a good home and lives in a nice neighborhood. When you first see him, he looks normal in every way. But David has a problem.

In school, David's teacher says he is doing poorly; he is very distractible, disruptive, and can't seem to sit still. He had been referred to the school psychologist who spent time observing David in the classroom, talking with his teacher and his parents and giving him a variety of psychological tests. As everyone suspected, David's tests showed that he was very bright. True, his academic scores were somewhat low, but not that low. The psychologist felt that there was no evidence of a serious emotional problem or problems at home. However, David's mother did confide that her son is much more active than other children his age and that she often has a hard time controlling his behavior at home. She went on to say that other children don't like to play with him because he always gets into fights with them. She talked to her pediatrician but couldn't get a definitive diagnosis and she's still looking for some answers.

Although the diagnosis is a difficult one to make, there is a good possibility that David is a hyperactive child. His hyperactivity could also be a symptom of something known as Attention Deficit Disorder or ADD. There are many unanswered questions about hyperactivity but investigators have begun to uncover some of the mysteries of this complex problem. At one time, in fact, ADD had been known as minimal brain dysfunction. Research has shown that children with ADD may or may not be hyperactive and, to a large extent, a diagnosis of ADD or hyperactivity is based on clinical judgment.

Children with ADD are prone to learning problems, but the kind of problems ADD children display are very different from other kinds of learning disabilities. Often their learning deficiencies are not as severe or as clear-cut as LD children so that children with ADD seem to slip between the cracks of our educational system. To make the matter more complicated, there are children who are emotional disturbed or who are hyperactive **without** having ADD. For simplicity, this article will focus only on the child with ADD and hyperactivity (ADDH).

What kind of special problems do ADDH children have? The first problem is diagnosis. Often, these children are seen as emotionally disturbed and are mistakenly treated as such. One of the major problems that ADDH children encounter is peer rejection. This rejection can result in a negative self-image which in turn can contribute to emotional problems. Often, but not always, children with ADDH are clumsy and poor athletes. In boys, this further distances them from their peers. Although ADDH is frequently associated with neurological problems, sometimes these can be determined medically and sometimes not. The child's environment often contributes to the

problem, but in most cases a child with ADDH would have the problem regardless of the environment. This is important to understand since parents and teachers often perceive the ADDH child as being willfully "bad;" this is rarely the case. The ADDH child is not misbehaving on purpose! This is not to say, however, that the ADDH child can't be taught to exercise better impulse control or improve his attention span.

ADDH children all need a well-structured, predictable school environment. Because these children are highly distractible, they have particular difficulty with excessive stimulation—either emotional, physical, or sensorial. When the ADDH child is being taught something new, keeping all stimulation at a low level tends to reduce the level of hyperactivity. Recent studies have demonstrated the effectiveness of biofeedback in helping ADDH children complete classroom assignments. Using biofeedback machines, ADDH children are first shown how to relax and how to make their bodies relax. The hyperactive children who participated in the relaxation training program and who were trained to use biofeedback while doing classwork tended to show more improvement than ADDH children who did not receive the training. What was most important was not the biofeedback per se, but that the children shared directly in the management of their behavior.

Other successful methods include having the ADDH child self-evaluate his own behavior. In one such procedure in which inattention was the identifed problem, the teacher signaled the child to record his inappropriate behavior on a special data sheet. When used in the classroom, this method was found to be effective in improving attentiveness. This approach is a bit different from more traditional behavior modification programs and again points to the importance of having the ADDH child share in the responsibility of dealing with his behavior.

Does psychotherapy help or is medication enough? The need for medication must be determined by a qualified physician who has had either training or experience with this special problem. Medication has been very effective, but other approaches are valuable. Children with ADD often need someone they can trust and in whom they can confide. They need to understand the nature of their problem and to know that there is much they can do to help themselves. Parents and families are often frustrated and overwhelmed and they, too, are in need of support, guidance, and good information.

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